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STATE MS.-DESOTO CO.
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BK 83 PG 748
W.E. DAVIS CIR. CLK.

ADVANCE HEALTH-CARE DIRECTIVE

NOTICE TO PERSON EXECUTING THIS DOCUMENT This is an important legal document. Before executing this document, you should know these important facts:

You have the right to give instructions about your own healthcare. You also have the right to name someone else to make healthcare decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician. If you use this form, you may complete or modify all or any party of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make healthcare decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now and even though you are still capable. Unless related to you, your agent may not be an owner, operator, or employee of a residential long-term health-care institution at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;

(b) Select or discharge health-care providers and institutions;

(c) Approve or disapprove diagnostic tests, surgical procedures, programs or medication, and orders not to resuscitate; and

(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of healthcare.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provisions, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end and have the form witnessed by one of the two alternative methods listed below, Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health-care directive or replace this form at any time.

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PART 1

POWER OF ATTORNEY FOR HEALTH CARE OF MARY E. CARROLL

(1) **DESIGNATION OF AGENT**: I designate the following individual as my agent to make health-care decisions for me:

SHERRY CARROLL RAGGHIANTI
(Name of individual you choose as agent)

7790 AUBURN COVE, SOUTHAVEN, MISSISSIPPI 38671
(Address; City; State; Zip Code)

662-393-0383
(Home phone)

(2) **AGENT'S AUTHORITY**: My agent is authorized to make all healthcare decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive.

(3) **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE**: My agent's authority becomes effective immediately.

(4) **AGENT'S OBLIGATION**: My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) **NOMINATION OF GUARDIAN**: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate NO alternate agents.

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PART 2

INSTRUCTIONS FOR HEALTH CARE

(6) **END-OF-LIFE DECISIONS**: I direct that my healthcare providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have marked below:

[x] (a) Choice Not To Prolong Life

I do not want my life to be prolonged if my physician, with the concurrence of two (2) other physicians believes, (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, or

[ ] (b) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(7) **ARTIFICIAL NUTRITION AND HYDRATION**: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box. If I mark this box [ ], artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) **RELIEF FROM PAIN**: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

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(9) **OTHER WISHES**: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

My agent Sherry Carroll Ragghianit make all health care decisions for me.

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PART 3

PRIMARY PHYSICIAN

(OPTIONAL)

(10) I designate the following physician as my primary physician:

Dr. Robert Kraus
(Name of Physician)

6005 Park Avenue, Memphis TN
(Address; City; State; Zip Code)

901-761-9097
(Phone)

(11) **EFFECT OF COPY:** A copy of this form has the same effect as the original.

(12) **SIGNATURES:** Sign and date the form here:

12-20-1999 Ms. Mary Elizabeth Carroll
(Date) (Signature) MARY E. CARROLL

Ms. MARY ELIZABETH CARROLL
(Printed Name) MARY E. CARROLL

1759 NORTHFIELD DRIVE, SOUTHAVEN, MISSISSIPPI 38671
(address)

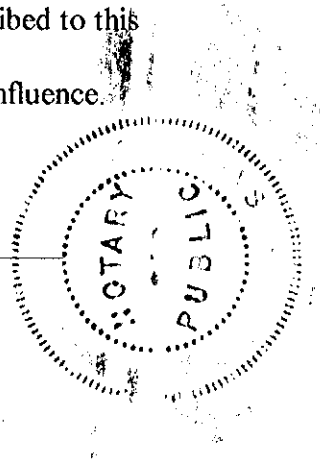
STATE OF MISSISSIPPI

COUNTY OF DESOTO

On this 20 day of December, in the year 1999, before me, personally appeared MARY E. CARROLL, personally known to me (or proved to me on the basis of satisfactory evidence) to

be the person whose name is subscribed to this instrument, and acknowledged that she executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

Brandie Leath
NOTARY PUBLIC



My commission expires:

2-22-2002

Angelita Fisher, Atty.
9054 Mill Branch
Southaven, MS. 38671
662-342-1444